Complete Summary

GUIDELINE TITLE

Enhancing motivation for change in substance abuse treatment.

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 35 Consensus Panel. Enhancing motivation for change in substance abuse treatment. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999 . (Treatment improvement protocol (TIP) series; no. 35). [313 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Substance use disorders

GUIDELINE CATEGORY

Counseling
Screening
Treatment

CLINICAL SPECIALTY

Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To link research to practice by providing clear applications of motivational approaches in clinical practice and treatment programs.
- To shift the conception of client motivation for change toward a view that empowers the treatment provider to elicit motivation.
- To show how substance abuse treatment staff can influence change by developing a therapeutic relationship that respects and builds on the client's autonomy and, at the same time, makes the treatment clinician a partner in the change process
- To describe different motivational interventions that can be used at all stages of the change process, from precontemplation and preparation to action and maintenance
- To inform readers of the research, results, tools, and assessment instruments related to enhancing motivation

TARGET POPULATION

Substance abusers

INTERVENTIONS AND PRACTICES CONSIDERED

Screening and Assessment Instruments

1. Alcohol and Drug Consequences Questionnaire (ADCQ)
2. Alcohol (and Illegal Drugs) Decisional Balance Scale
3. Alcohol Effects Questionnaire
4. Alcohol Expectancy Questionnaire--III (Adult)
5. Alcohol Use Disorders Identification Test (AUDIT)
6. Brief Situational Confidence Questionnaire (BSCQ)
7. Personal Feedback Report
8. Understanding Your Personal Feedback Report
9. Readiness To Change Questionnaire (Treatment Version) (RCQ-TV)
10. Situational Confidence Questionnaire (SCQ-39)
11. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A, 8D)
12. University of Rhode Island Change Assessment Scale (URICA)
13. What I Want From Treatment Questionnaire

Counseling and Treatment

1. The transtheoretical stages-of-change model: precontemplation, contemplation, preparation, action, and maintenance
2. The FRAMES approach
3. Decisional balance exercises
4. Developing discrepancy
5. Flexible pacing
6. Personal contact with clients who are not actively in treatment
7. Motivational strategies
8. Motivational interviewing
9. Application of motivational strategies to each stage of the transtheoretical stages-of-change model
10. Intervening through significant others
11. The Johnson Intervention
12. Unilateral Family Therapy
13. Community Reinforcement Approach
14. Albany-Rochester Interventional Sequence for Engagement

MAJOR OUTCOMES CONSIDERED

- Motivation level
- Participation and compliance rates
- Consumption and abstinence rates
- Psychosocial functioning
- Dropout rates
- Referral rates

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

All Treatment Improvement Protocols (TIPs) are produced after a major literature search followed by a meta-analysis by skilled professionals on the contractor's staff. Then the research-based evidence is combined with whatever field-based experience is shared at the consensus panel.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A review of the cost-effectiveness of treatments for alcohol use disorders concluded that brief motivational counseling ranked among the most effective treatment modalities, based on weighted evidence from rigorous clinical trials. Brief motivational counseling was also the least costly--making it the most cost-effective treatment modality of the 33 evaluated. Although cautioning that it was an approximation that requires refinement, the same study found a negative correlation between effectiveness and costs for the most traditional forms of treatment for alcohol use disorders and highlighted a growing trend to favor effective outpatient care over less effective or less studied--but far more expensive--inpatient, hospital-based, or residential care.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The Consensus Panel's recommendations, summarized below, are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2).

Conceptualizing Motivation

In the past 15 years, considerable research has focused on ways to better motivate substance-using clients to initiate and continue substance abuse treatment. A series of motivational approaches has been developed to elicit and enhance a substance-using client's motivation to change. These approaches are based on the following assumptions about the nature of motivation:

- Motivation is a key to change. (2)
- Motivation is multidimensional. (2)
- Motivation is a dynamic and fluctuating state. (2)
- Motivation is interactive. (2)
- Motivation can be modified. (2)
- The clinician's style influences client motivation. (2)

To incorporate these assumptions about motivation while encouraging a client to change substance-using behavior, the clinician can use the following strategies:

- Focus on the client's strengths rather than his weaknesses. (2)
- Respect the client's autonomy and decisions. (2)
- Make treatment individualized and client centered. (1)
- Do not depersonalize the client by using labels like "addict" or "alcoholic." (2)
- Develop a therapeutic partnership. (2)
- Use empathy, not authority or power. (1)
- Focus on early interventions. Extend motivational approaches into nontraditional settings. (2)
- Focus on less intensive treatments. (1)
- Recognize that substance abuse disorders exist along a continuum. (2)
- Recognize that many clients have more than one substance use disorder. (1)
- Recognize that some clients may have other coexisting disorders that affect all stages of the change process. (1)
- Accept new treatment goals, which involve interim, incremental, and even temporary steps toward ultimate goals. (2)
- Integrate substance abuse treatment with other disciplines. (2)

Motivational approaches build on these ideas. They seek to shift control away from the clinician and back to the client. They emphasize treating the client as an individual. They also recognize that treating substance abuse is a cyclical rather than a linear process and that recurrence of use does not necessarily signal failure.

Transtheoretical Model of Change

Substantial research has focused on the determinants and mechanisms of personal change. Theorists have developed various models for how behavior change happens. One perspective sees external consequences as being largely responsible for influencing individuals to change. Another model views intrinsic motivations as causing substance abuse disorders. Others believe that motivation is better described as a continuum of readiness than as one consisting of separate stages of change.

The transtheoretical stages-of-change model, described in Chapter 1 of the original guideline document, emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that make up the biopsychosocial framework for understanding addiction. This model of change provides the foundation for this treatment improvement protocol. The five stages of change are precontemplation, contemplation, preparation, action, and maintenance. These stages can be conceptualized as a cycle through which clients move back and forth. The stages are not viewed as linear, such that clients enter into one stage and then directly progress to the next. Framing clients' treatment within the stages of change can help the clinician better understand clients' treatment progress.

This model also takes into account that for most people with substance abuse problems, recurrence of substance use is the rule, not the exception. After a return to substance use, clients usually revert to an earlier change stage--not always to maintenance or action, but many times to some level of contemplation. In this model, recurrence is not equivalent to failure and does not mean that a client has abandoned a commitment to change. Thus, recurrence is not considered a stage but an event that can occur at any point along the cycle of recovery. Based on research and clinical experience, the Consensus Panel endorses the transtheoretical model as a useful model of change (1, 2); however, it is important to note that the model's use has been primarily conceptual and that no current technology is available to definitively determine an individual's stage of readiness for change.

Motivational Interventions

A motivational intervention is any clinical strategy designed to enhance client motivation for change. It can include counseling, client assessment, multiple sessions, or a 30-minute brief intervention. To understand what prompts a person to reduce or eliminate substance use, investigators have searched for the critical components--the most important and common elements that inspire positive change--of effective interventions. The Consensus Panel considers the following elements of current motivational approaches to be important:

- The FRAMES approach (1)
- Decisional balance exercises (1)
- Developing discrepancy (1)
- Flexible pacing (2)
- Personal contact with clients who are not actively in treatment (1)

The FRAMES approach consists of the following components:

- Feedback regarding personal risk or impairment is given to the individual following an assessment of substance use patterns and associated problems. This feedback usually compares the client's scores or ratings on standard tests with normative data from the general population or specified treatment groups.
- Responsibility for change is placed squarely and explicitly with the individual. Clients have the choice to either continue their substance use behavior or change it.
- Advice about changing--reducing or stopping--substance use is clearly given to the individual by the clinician in a nonjudgmental manner. It is better to suggest than to tell. Asking clients' permission to offer advice can make clients more receptive to that advice.
- Menu of self-directed change options and treatment alternatives is offered to the client.
- Empathic counseling, showing warmth, respect, and understanding, is emphasized. Empathy entails reflective listening.
- Self-efficacy or optimistic empowerment is engendered in the person to encourage change.

Research has shown that simple motivation-enhancing interventions are effective for encouraging clients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more compliant.

The simplicity and universality of the concepts underlying motivational interventions permit broad-scale application in many different settings and offer great potential to reach individuals with many types of problems and in many different cultures. This is important because treatment professionals work with a wide range of clients who differ with regard to ethnic and racial background, socioeconomic status, education level, gender, age, sexual orientation, type and severity of substance abuse problems, physical health, and psychological health. Although the principles and mechanisms of enhancing motivation to change seem to be broadly applicable, there may be important differences among populations and cultural contexts regarding the expression of motivation for change and the importance of critical life events. Therefore, clinicians should be thoroughly familiar with the populations with whom they expect to establish therapeutic relationships. (2)

Because motivational strategies emphasize clients' responsibilities to voice personal goals and values as well as to make choices among options for change, clinicians should understand and respond in a nonjudgmental way to expressions of cultural differences. They should identify elements in a population's values that present potential barriers to change. Clinicians should learn what personal and material resources are available to clients and be sensitive to issues of poverty, social isolation, or recent losses in offering options for change or probing personal values. In particular, it should be recognized that access to financial and social resources is an important part of the motivation for and process of change. (2)

Motivational Interviewing

Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. While conducting a motivational

interview, the clinician is directive yet client centered, with a clear goal of eliciting self-motivational statements and behavioral change from the client, and seeking to create client discrepancy to enhance motivation for positive change. The Consensus Panel recommends that motivational interviewing be seen not as a set of techniques or tools, but rather as a way of interacting with clients. (2) The Panel believes that motivational interviewing is supported by the following principles:

- Ambivalence about substance use and change is normal and constitutes an important motivational obstacle in recovery. (2)
- Ambivalence can be resolved by working with the client's intrinsic motivations and values. (2)
- The alliance between client and clinician is a collaborative partnership to which each brings important expertise. (2)
- An empathic, supportive, yet directive counseling style provides conditions within which change can occur. (Direct argument and aggressive confrontation tend to increase client defensiveness, reducing the likelihood of change.) (2)

The motivational interviewing style facilitates an exploration of stage-specific motivational conflicts that can potentially hinder further progress (1). However, each dilemma also offers an opportunity to use the motivational style as a way of helping clients explore and resolve opposing attitudes.

The Consensus Panel recognizes that successful motivational interviewing will entail being able to:

- Express empathy through reflective listening. (1)
- Communicate respect for and acceptance of clients and their feelings. (2)
- Establish a nonjudgmental, collaborative relationship. (2)
- Be a supportive and knowledgeable consultant. (2)
- Compliment rather than denigrate. (2)
- Listen rather than tell. (2)
- Gently persuade, with the understanding that change is up to the client. (2)
- Provide support throughout the process of recovery. (2)
- Develop discrepancy between clients' goals or values and current behavior, helping clients recognize the discrepancies between where they are and where they hope to be. (2)
- Avoid argument and direct confrontation, which can degenerate into a power struggle. (2)
- Adjust to, rather than oppose, client resistance. (2)
- Support self-efficacy and optimism: that is, focus on clients' strengths to support the hope and optimism needed to make change. (2)

Clinicians who adopt motivational interviewing as a preferred style have found that the following five strategies are particularly useful in the early stages of treatment:

1. Ask open-ended questions. Open-ended questions cannot be answered with a single word or phrase. For example, rather than asking, "Do you like to drink?" ask, "What are some of the things that you like about drinking?" (2)

2. Listen reflectively. Demonstrate that you have heard and understood the client by reflecting what the client said. (2)
3. Summarize. It is useful to summarize periodically what has transpired up to that point in a counseling session. (2)
4. Affirm. Support and comment on the client's strengths, motivation, intentions, and progress. (2)
5. Elicit self-motivational statements. Have the client voice personal concerns and intentions, rather than try to persuade the client that change is necessary. (2)

Tailoring Motivational Interventions to the Stages of Change

Individuals appear to need and use different kinds of help, depending on which stage of readiness for change they are currently in and to which stage they are moving. (2) Clients who are in the early stages of readiness need and use different kinds of motivational support than do clients at later stages of the change cycle.

To encourage change, individuals in the precontemplation stage must increase their awareness. (2) To resolve their ambivalence, clients in the contemplation stage should choose positive change over the status quo. (2) Clients in the preparation stage must identify potential change strategies and choose the most appropriate one for their circumstances. Clients in the action stage must carry out change strategies. This is the stage toward which most formal substance abuse treatment is directed. During the maintenance stage, clients may have to develop new skills that help maintain recovery and a healthy lifestyle. Moreover, if clients resume their problem substance use, they need help to recover as quickly as possible and reenter the change process.

From precontemplation to contemplation

According to the stages-of-change model, individuals in the precontemplation stage are not concerned about their substance use or are not considering changing their behavior. These substance users may remain in precontemplation or early contemplation for years, rarely or never thinking about change. Often, a significant other finds the substance user's behavior problematic. Chapter 4 in the original document discusses a variety of proven techniques and gentle tactics that clinicians can use to address the topic of substance abuse with people who are not thinking of change. Use of these techniques will serve to (1) create client doubt about the commonly held belief that substance abuse is "harmless" and (2) lead to client conviction that substance abuse is having, or will in the future have, significant negative results. The chapter suggests that clinicians practice the following:

- Commend the client for coming to substance abuse treatment. (2)
- Establish rapport, ask permission to address the topic of change, and build trust. (2)
- Elicit, listen to, and acknowledge the aspects of substance use the client enjoys. (2)
- Evoke doubts or concerns in the client about substance use. (2)
- Explore the meaning of the events that brought the client to treatment or the results of previous treatments. (2)

- Obtain the client's perceptions of the problem. (2)
- Offer factual information about the risks of substance use. (2)
- Provide personalized feedback about assessment findings. (2)
- Help a significant other intervene. (2)
- Examine discrepancies between the client's and others' perceptions of the problem behavior. (2)
- Express concern and keep the door open. (2)

The assessment and feedback process can be an important part of the motivational strategy because it informs clients of how their own substance use patterns compare with norms, what specific risks are entailed, and what damage already exists or is likely to occur if changes are not made.

Giving clients personal results from a broad-based and objective assessment, especially if the findings are carefully interpreted and compared with norms or expected values, can be not only informative but also motivating (1). Providing clients with personalized feedback on the risks associated with their own use of a particular substance--especially for their own cultural and gender groups--is a powerful way to develop a sense of discrepancy that can motivate change.

Intervening through significant others

Considerable research shows that involvement of family members or significant others can help move substance-using persons toward contemplation of change, entry into treatment, involvement and retention in the therapeutic process, and successful recovery (1). Involving significant others in the early stages of change can greatly enhance a client's commitment to change by addressing the client's substance use in the following ways:

- Providing constructive feedback to the client about the costs and benefits associated with her substance abuse (2)
- Encouraging the resolve of the client to change the negative behavior pattern (2)
- Identifying the client's concrete and emotional obstacles to change (2)
- Alerting the client to social and individual coping resources that lead to a substance-free lifestyle (2)
- Reinforcing the client for employing these social and coping resources to change the substance use behavior (2)

The clinician can engage a significant other by asking the client to invite the significant other to a treatment session. Explain that the significant other will not be asked to monitor the client's substance use but that the significant other can perform a valuable role by providing emotional support, identifying problems that might interfere with treatment goals, and participating in activities with the client that do not involve substance use. To strengthen the significant other's belief in his capacity to help the client, the clinician can use the following strategies:

- Positively describe the steps used by the significant other that have been successful (define "successful" generously). (2)
- Reinforce positive comments made by the significant other about the client's current change efforts. (2)

- Discuss future ways in which the client might benefit from the significant other's efforts to facilitate change. (2)

Clinicians should use caution when involving a significant other in motivational counseling. Although a strong relationship between the significant other and the client is necessary, it is not wholly sufficient. The significant other must also support a client's substance-free life, and the client must value that support (1). A significant other who is experiencing hardships or emotional problems stemming from the client's substance use may not be a suitable candidate (1). Such problems can preclude the significant other from constructively participating in the counseling sessions, and it may be better to wait until the problems have subsided before including a significant other in the client's treatment (1).

In general, the significant other can play a vital role in influencing the client's willingness to change; however, the client must be reminded that the responsibility to change substance use behavior is hers. (2)

Motivational interventions and coerced clients

An increasing number of clients are mandated to obtain treatment by an employer or employee assistance program, the court system, or probation and parole officers. Others are influenced to enter treatment because of legal pressures. The challenge for clinicians is to engage coerced clients in the treatment process. A stable recovery cannot be maintained by external (legal) pressure only; motivation and commitment must come from internal pressure. If you provide interventions appropriate to their stage, coerced clients may become invested in the change process and benefit from the opportunity to consider the consequences of use and the possibility of change--even though that opportunity was not voluntarily chosen. (2)

From contemplation to preparation

Extrinsic and intrinsic motivators should be considered when trying to increase a client's commitment to change and move the client closer to action because these motivators can be examined to enhance decision making, thereby enhancing the client's commitment. Many clients move through the contemplation stage acknowledging only the extrinsic motivators pushing them to change or that brought them to treatment. Help the client discover intrinsic motivators, which typically move the client from contemplating change to acting. (2) In addition to the standard practices for motivational interviewing (e.g., reflective listening, asking open-ended questions), clinicians can help spur this process of changing extrinsic motivators to intrinsic motivators by doing the following:

- Show curiosity about clients. Because a client's desire to change is seldom limited to substance use, he may find it easier to discuss changing other behaviors. This will help strengthen the therapeutic alliance. (2)
- Reframe a client's negative statement about perceived coercion by re-expressing the statement with a positive spin. (2)

Clinicians can use decisional balancing strategies to help clients thoughtfully consider the positive and negative aspects of their substance use. (1) The ultimate purpose, of course, is to help clients recognize and weigh the negative

aspects of substance use so that the scale tips toward beneficial behavior. Techniques to use in decisional balancing exercises include the following:

- Summarize the client's concerns. (2)
- Explore specific pros and cons of substance use behavior. (1)
- Normalize the client's ambivalence. (2)
- Reintroduce feedback from previous assessments. (1)
- Examine the client's understanding of change and expectations of treatment. (1)
- Reexplore the client's values in relation to change. (2)

Throughout this process, emphasize the clients' personal choices and responsibilities for change. The clinician's task is to help clients make choices that are in their best interests. This can be done by exploring and setting goals. Goal-setting is part of the exploring and envisioning activities characteristic of the early and middle preparation stage. The process of talking about and setting goals strengthens commitment to change. (1)

During the preparation stage, the clinician's tasks broaden from using motivational strategies to increase readiness--the goals of precontemplation and contemplation stages--to using these strategies to strengthen a client's commitment and help her make a firm decision to change. At this stage, helping the client develop self-efficacy is important. (2) Self-efficacy is not a global measure, like self-esteem; rather, it is behavior specific. In this case, it is the client's optimism that she can take action to change substance-use behaviors.

From preparation to action

As clients move through the preparation stage, clinicians should be alert for signs of clients' readiness to move into action. There appears to be a limited period of time during which change should be initiated. (2) Clients' recognition of important discrepancies in their lives is too uncomfortable a state to remain in for long, and unless change is begun they can retreat to using defenses such as minimizing or denying to decrease the discomfort. (2) The following can signal a client's readiness to act:

- The client's resistance (i.e., arguing, denying) decreases. (2)
- The client asks fewer questions about the problem. (2)
- The client shows a certain amount of resolve and may be more peaceful, calm, relaxed, unburdened, or settled. (2)
- The client makes direct self-motivational statements reflecting openness to change and optimism. (2)
- The client asks more questions about the change process. (2)
- The client begins to talk about how life might be after a change. (2)
- The client may have begun experimenting with possible change approaches such as going to an Alcoholics Anonymous meeting or stopping substance use for a few days. (2)

Mere vocal fervor about change, however, is not necessarily a sign of dogged determination. Clients who are most vehement in declaring their readiness may be desperately trying to convince themselves, as well as the clinician, of their commitment.

When working with clients in the preparation stage, clinicians should try to:

- Clarify the client's own goals and strategies for change. (2)
- Discuss the range of different treatment options and community resources available to meet the client's multiple needs. (2)
- With permission, offer expertise and advice. (2)
- Negotiate a change--or treatment--plan and a behavior contract (2); take into consideration:
    a. Intensity and amount of help needed
    b. Timeframe
    c. Available social support, identifying who, where, and when
    d. The sequence of smaller goals or steps needed for a successful plan
    e. Multiple problems, such as legal, financial, or health concerns
- Consider and lower barriers to change by anticipating possible family, health, system, and other problems. (2)
- Help the client enlist social support (e.g., mentoring groups, churches, recreational centers). (2)
- Explore treatment expectancies and client role. (2)
- Have clients publicly announce their change plans to significant others in their lives. (2)

From action to maintenance

A motivational counseling style has most frequently been used with clients in the precontemplation through preparation stages as they move toward initiating behavioral change. Some clients and clinicians believe that formal, action-oriented substance abuse treatment is a different domain and that motivational strategies are no longer required. This is not true for two reasons. First, clients may still need a surprising amount of support and encouragement to stay with a chosen program or course of treatment. Even after a successful discharge, they may need support and encouragement to maintain the gains they have achieved and to know how to handle recurring crises that may mean a return to problem behaviors (2). Second, many clients remain ambivalent in the action stage of change or vacillate between some level of contemplation--with associated ambivalence--and continuing action (2). Moreover, clients who do take action are suddenly faced with the reality of stopping or reducing substance use. This is more difficult than just contemplating action. The first stages of recovery require only thinking about change, which is not as threatening as actually implementing it.

Clients' involvement or participation in treatment can be increased when clinicians:

- Develop a nurturing rapport with clients. (2)
- Induct clients into their role in the treatment process. (2)
- Explore what clients expect from treatment and determine discrepancies. (2)
- Prepare clients so that they know there may be some embarrassing, emotionally awkward, and uncomfortable moments but that such moments are a normal part of the recovery process. (2)
- Investigate and resolve barriers to treatment. (2)
- Increase congruence between intrinsic and extrinsic motivation. (2)
- Examine and interpret noncompliant behavior in the context of ambivalence. (2)

- Reach out to demonstrate continuing personal concern and interest to encourage clients to remain in the program. (2)

Clients who are in the action stage can be most effectively helped when clinicians:

- Engage clients in treatment and reinforce the importance of remaining in recovery. (2)
- Support a realistic view of change through small steps. (2)
- Acknowledge difficulties for clients in early stages of change. (2)
- Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these. (2)
- Assist the client in finding new reinforcers of positive change. (2)
- Assess whether the client has strong family and social support. (2)

The next challenge that clients and clinicians face is maintaining change. With clients in the maintenance stage, clinicians will be most successful if they can:

- Help the client identify and sample substance-free sources of pleasure--i.e., new reinforcers. (1)
- Support lifestyle changes. (2)
- Affirm the client's resolve and self-efficacy. (2)
- Help the client practice and use new coping strategies to avoid a return to substance use. (2)
- Maintain supportive contact. (2)

After clients have planned for stabilization by identifying risky situations, practicing new coping strategies, and finding their sources of support, they still have to build a new lifestyle that will provide sufficient satisfaction and can compete successfully against the lure of substance use. A wide range of life changes ultimately needs to be made if clients are to maintain lasting abstinence. Clinicians can help this change process by using competing reinforcers. (1) A competing reinforcer is anything that clients enjoy that is or can become a healthy alternative to drugs or alcohol as a source of satisfaction.

The essential principle in establishing new sources of positive reinforcement is to get clients involved in generating their own ideas. Clinicians should explore all areas of clients' lives for new reinforcers. Reinforcers should not come from a single source or be of the same type. That way, a setback in one area can be counterbalanced by the availability of positive reinforcement from another area. Since clients have competing motivations, clinicians can help them select reinforcers that will win out over substances over time.

Following are a number of potential competing reinforcers that can help clients:

- Doing volunteer work, thus filling time, connecting with socially acceptable friends, and improving their self-efficacy (2)
- Becoming involved in 12-Step-based activities and other self-help groups (2)
- Setting goals to improve their work, education, exercise, and nutrition (2)
- Spending more time with their families and significant others (2)
- Participating in spiritual or cultural activities (2)
- Socializing with nonsubstance-using friends (2)

- Learning new skills or improving in such areas as sports, art, music, and other hobbies (2)

Contingency reinforcement systems, such as voucher programs, have proven to be effective when community support and resources are available. (1) Research has shown that these kinds of reinforcement systems can help to sustain abstinence in drug abusers. The rationale for this type of incentive program is that an appealing external motivator can be used as an immediate and powerful reinforcer to compete with substance use reinforcers. Not all contingent incentives have to have a monetary value. In many cultures, money is not the most powerful reinforcer.

Measuring Client Motivation

Because motivation is multidimensional, it cannot be easily measured with one instrument or scale. Instead, the Consensus Panel recommends that substance abuse treatment staff use a variety of tools to measure several dimensions of motivation, including (2):

- Self-efficacy
- Importance of change
- Readiness to change
- Decisional balancing
- Motivations for using substances

Integrating Motivational Approaches Into Treatment Programs

One of the principles of current health care management is that the most intensive and expensive treatments should be used only with those with the most serious problems or with those who have not responded to lesser interventions. Motivational interventions can serve many purposes in treatment settings:

- As a means of rapid engagement in the general medical setting to facilitate referral to treatment (2)
- As a first session to increase the likelihood that a client will return and to deliver a useful service if the client does not return (1)
- As an empowering brief consultation when a client is placed on a waiting list, rather than telling a client to wait for treatment (1)
- As a preparation for treatment to increase retention and participation (1)
- To help clients coerced into treatment to move beyond initial feelings of anger and resentment (2)
- To overcome client defensiveness and resistance (2)
- As a stand-alone intervention in settings where there is only brief contact (1)
- As a counseling style used throughout the process of change (1)

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

The benefits of employing motivational enhancement techniques include:

- Inspiring motivation to change
- Preparing clients to enter treatment
- Engaging and retaining clients in treatment
- Increasing participation and involvement in treatment
- Improving treatment outcomes including reducing substance use to less harmful levels, increasing abstinence rates, and increasing referral rates
- Improving health and psychosocial functioning
- Improving employment stability
- Encouraging a rapid return to treatment following a missed appointment or if symptoms recur
- Lowering treatment costs

Subgroups Most Likely to Benefit:

Motivational enhancement approaches may be especially beneficial to particular populations (e.g., court-mandated offenders) with a low motivation for change.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Throughout this Treatment Improvement Protocol, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition [DSM-IV] [American Psychiatric Association, 1994]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, commencing with this Treatment Improvement Protocol, it will be used to denote both substance dependence and substance abuse disorders.

The term does relate to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders as described by the DSM-IV.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols are distributed to facilities and individuals across the country.

The original Treatment Improvement Protocol document includes resources to help providers implement the recommendations in the Treatment Improvement Protocol.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol Series 35 Consensus Panel. Enhancing motivation for change in substance abuse treatment. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999 . (Treatment improvement protocol (TIP) series; no. 35). [313 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 35 Consensus Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Consensus Panel Members: William R. Miller, Consensus Panel Chair; Linda C. Sobell; Rosalyn Harris-Offutt; Ed Bernstein; Ray Daw; Cheryl Grills; Jeffrey M. Georgi; Allen Zweben; Carole Otero; Carlo C. DiClemente.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 18, 2000. It was verified by the guideline developer as of January 25, 2001.

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